MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1757 — Reg. Dist. No. 01761

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M d. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: R.D.3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Rufus — Middle — Last Anthony
4. DATE OF DEATH: Month Feb. — Day 26 — Year 1959

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr.1,1904
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Anthony
14. MOTHER'S MAIDEN NAME: Cecilia-?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Banks Whitaker-R.D.3 Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Bilateral suppurative bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: about 10 days
491 X
DUE TO (b): with gangrene of lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bleeding gastric ulcer and ulcer of diverticulum of duodenum.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 18, 1959 to Feb. 26, 1959, that I last saw the deceased alive on Feb. 26, 1959, and that death occurred at 8:20a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 2/26/59
PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/2/59
22c. NAME OF CEMETERY OR CREMATORY: Griffin Cem.
22d. LOCATION (City, town, or county) (State): Cedar Hill. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edw. R. Bell — ADDRESS: 909 Poplar St., Wilm. Del.
24a. REC'D BY REGISTRAR DATE: MAR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hirons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01762

1772

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East Md
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hilda — Middle: M. — Last: Betker

4. DATE OF DEATH: Month: 2 — Day: 21 — Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-11-1904

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E.Goodnow

14. MOTHER'S MAIDEN NAME: Ethel W.Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Address: George F.Betker North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 years
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Essential Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 14 Nov, 19 58, to 21 Feb, 19 59, that I last saw the deceased alive on 18 Feb, 19 59, and that death occurred at 9:40 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Hartman M.D. ADDRESS (Street, city or town, state): North East, Md DATE SIGNED: 23 Feb 59

PHYSICIAN'S NAME (Type): Klaus H. Hartman (M.D.)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-25-1959

22c. NAME OF CEMETERY OR CREMATORY: Methodist

22d. LOCATION (City, town, or county) (State): North East, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: Charles L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1758 — Reg. Dist. No. 01763

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: DeVine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen R.F.D. #2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMANDA — Middle — Last BOYLE

4. DATE OF DEATH: Month Feb. — Day 6 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 13, 1875

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edwin Hill

14. MOTHER'S MAIDEN NAME: Mary Krauss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ralph E Kerwin
Address: 123 So. Broad St. Phila. 9, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiac Insufficiency with
DUE TO
(b): Hypertensive Cardiac Hypertrophy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

443X

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 28, 19 59, to Feb. 6, 19 59, that I last saw the deceased alive on Feb 5, 19 59, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Ralph Andrews Jr M.D.
ADDRESS (Street, city or town, state): 233 E Main St.
DATE SIGNED: 2/6/59
PHYSICIAN'S NAME (Type): J. RALPH ANDREWS, JR ELKTON/MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/9/1959
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
22d. LOCATION (City, town, or county): Colora (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Earl Tyson
ADDRESS: RisingSun, Md
24a. REC'D BY REGISTRAR DATE: FEB 10 '59
24b. REGISTRAR'S SIGNATURE: Curtis L. Rivers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1773

CERTIFICATE OF DEATH

01764 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East, Rural
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East, Rural
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Edmund — Last: Crothers
4. DATE OF DEATH: Month: February — Day: 9 — Year: 1959
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: October 27, 1867
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: James C. Crothers
14. MOTHER'S MAIDEN NAME: Hannah Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-12-4548
INFORMANT: Mr. Charles T. Crothers, Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-6-1959, 19___, to 2-5-59, 19___, that I last saw the deceased alive on 2-6-59, 19___, and that death occurred at 4 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 2-10-59
PHYSICIAN'S NAME (Type): R.C.Dodson — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: Rosebank Cemetery
22d. LOCATION (City, town, or county) (State): Rising Sun, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun, Md.
24a. REC'D BY REGISTRAR — DATE: FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Gilbert L. Howard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1759

CERTIFICATE OF DEATH

01765
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East (Rural)
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl — Middle: Elizabeth — Last: Dean

4. DATE OF DEATH: Month: Feb. — Day: 13 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1894
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worker
10b. KIND OF BUSINESS OR INDUSTRY: Fireworks Factory
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther R. Cutlip
14. MOTHER'S MAIDEN NAME: Maggie Ann Shue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 236-26-2446
17. INFORMANT: Edgar W. Dean — Address: North East (Rural) Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Right cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days
332X
DUE TO (b): Cerebral Arteriosclerosis — 1 year
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophic osteo-Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Feb, 1959, to 13 Feb, 1959, that I last saw the deceased alive on 13 Feb, 1959, and that death occurred at 1 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D. — ADDRESS (Street, city or town, state): North East, Md — DATE SIGNED: 13 Feb 59

PHYSICIAN'S NAME (Type): Klaus H. Huebner M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: Feb 13-1959 — 22c. NAME OF CEMETERY OR CREMATORY: Old Drew Church Cemetery — 22d. LOCATION (City, town, or county) (State): Lewisburg West Va

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East, Md
24a. RECD BY REGISTRAR DATE: FEB 16 59
24b. REGISTRAR'S SIGNATURE: Curtiss L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01766

1760

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X R. D. 2 Elkton
d. STREET ADDRESS: White Hall Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Dill

4. DATE OF DEATH: Month: February — Day: 2, — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 4, 1904

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Norman George

14. MOTHER'S MAIDEN NAME: Annette Hollabaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Clarence E. Dill, Address: Elkton, Md. R. D. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH:

592 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chornic Nephritis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: R. C. Dodson M D

EXAMINER'S NAME (Type): R. C. Dodson, M.D.,

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 2/3/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/5/59

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery

22d. LOCATION (City, town, or county) (State): Cecil County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 5 '59

24b. REGISTRAR'S SIGNATURE: Ortt + S Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1761

CERTIFICATE OF DEATH

Reg. Dist. No. 01767

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON
d. STREET ADDRESS: UNION HOSPITAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Boyd Middle B. Last Edwards
4. DATE OF DEATH: Month Feb Day 10 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 10, 1959
9. AGE (In years last birthday): ____ yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours 2 Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ____
10b. KIND OF BUSINESS OR INDUSTRY: ____
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALLARD L. EDWARDS
14. MOTHER'S MAIDEN NAME: MYRTLE JUNE CASTELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ____
16. SOCIAL SECURITY NO: ____
17. INFORMANT: ALLARD L. EDWARDS — Address: ELKTON, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity
176X
DUE TO: ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ____
DUE TO
(c): ____
INTERVAL BETWEEN ONSET AND DEATH: 2 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 10, 1959 to Feb 10, 1959, that I last saw the deceased alive on Feb 10, 1959, and that death occurred at 11:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Milford H. Sprecher M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 2/11/59

PHYSICIAN'S NAME (Type): MILFORD H. SPRECHER

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/12/59
22c. NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PARK
22d. LOCATION (City, town, or county) (State): NR. ELKTON, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Pippin — ADDRESS: ELKTON, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b REGISTRAR'S SIGNATURE: Wm. S. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar or coroner, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1774

CERTIFICATE OF DEATH

01768

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First George Middle Littleton Last Ewing
4. DATE OF DEATH: Month Feb. Day 12 Year 195
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 25, 1875
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (State or foreign country): Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Amos Ewing
14. MOTHER'S MAIDEN NAME: Laura Ewing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-14-8902
INFORMANT: Mrs. Evan Job — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-15-, 1958, to 2-9-, 1959, that I last saw the deceased alive on 2-9-, 1959, and that death occurred at 4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 2-13-59

PHYSICIAN'S NAME (Type): R.C. Dodson — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 15, 1959
22c. NAME OF CEMETERY OR CREMATORY: Rosebank Cem.
22d. LOCATION (City, town, or county) (State): Calvert Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01769

1775

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 10 yrs.9 mo.
d NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Veterans Admin stration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission)
a. STATE: D. C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d STREET ADDRESS: 940 Randolph St. N.W.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle C. — Last FARLEY JR.

4. DATE OF DEATH: Month February — Day 27 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-27-09

9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Engineer

10b KIND OF BUSINESS OR INDUSTRY: General Elec. Co.

11. BIRTHPLACE (State or foreign country): Alabama

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John C. Farley, Sr.

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16 SOCIAL SECURITY NO.: unknown

17 INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
(a) Bronchopneumonia, bilateral, lower lobes, — INTERVAL BETWEEN ONSET AND DEATH: 7-10 days
420.0
DUE TO
(b) unresolved
Arteriosclerotic heart disease, severe — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m p. m. — Month, Day, Year 19 — VA

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 27 19 48 to February 27 19 59 that I last saw the deceased alive on and that death occurred at 6:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. P. Lacerva, M.D. — ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md. — DATE SIGNED: 3-2-59

PHYSICIAN'S NAME (Type): S. P. LACERVA — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/3/1959

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: C. Pennington & Son — ADDRESS: Havre de Grace, Md.

24a REC'D BY REGISTRAR DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1776

CERTIFICATE OF DEATH

01770
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROBERT Middle Last GARRISON

4. DATE OF DEATH Month Feb. Day 6, Year 1959

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August, 14, 1909
9. AGE (In years last birthday) 49 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Construction
10b. KIND OF BUSINESS OR INDUSTRY LABOR
11. BIRTHPLACE (State or foreign country) Cecilton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Garrison
14. MOTHER'S MAIDEN NAME Bessie Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 222-07-0816
17. INFORMANT Address Bessie Garrison, Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b) Carcinoma of Pancreas — 8 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 19 58 to Feb 6, 19 59, that I last saw the deceased alive on Feb 6, 19 59, and that death occurred at 7.00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Obenshain M.D. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED Feb 6 59

PHYSICIAN'S NAME (Type) Wallace Obenshain, Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 11, 1959
22c. NAME OF CEMETERY OR CREMATORY Cecilton Col. Cemetery
22d LOCATION (City, town, or county) Cecilton, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows ADDRESS Millington Md.
24a. REC'D BY REGISTRAR DATE FEB 13 '59
24b. REGISTRAR'S SIGNATURE Christine L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR:

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

Item 20 Film 239 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1777

01771 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMC. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS AISME BM 2/57

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural, Route 7
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X R D 1, Elkton, Maryland
STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard; Middle: F.; Last: Grayson
4. DATE OF DEATH: Month: February; Day: 28; Year: 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Aug. 23, 1923
9. AGE (In years last birthday): 35 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver
10b. KIND OF BUSINESS OR INDUSTRY: Fireworks
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Gillman B. Grayson
14. MOTHER'S MAIDEN NAME: Frances MaMafey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO: 169-18-1935
17. INFORMANT (Address): Willie Grayson, R.D. 1, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Compound fracture of occipital bone,
DUE TO (b): fracture 4th cerebral vertabrae,
DUE TO (c): crsuhed chest and other injuries extreme
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Was hit by a car
20c. TIME OF INJURY: Hour 2:30 a. m. p. m. — Month, Day, Year 2-28-59 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 7
20f. (City or town) Elkton, R.D., (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. C. Dodson M.D
EXAMINER'S NAME (Type): R. C. Dodson, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 2, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/3/59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d. LOCATION (City, town, or county) Elkton, (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Maryland
24a. REC'D BY REGISTRAR DATE MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AT5 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01772

1762 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 324 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Florence — Middle: L. — Last: Hayter

4. DATE OF DEATH: Month: February — Day: 9 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 24, 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H. Maxwell

14. MOTHER'S MAIDEN NAME: Laura Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: Mrs. Harry Biddle, Address: Elktonn Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardio Vascular failure — INTERVAL BETWEEN ONSET AND DEATH: 15 min

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): cerebral & gastrointestinal hemorrhage — 1 1/2 mos

DUE TO

(c): Hypertensive cardio vascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): generalized arterio sclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-29, 1958 to 2-9, 1959, that I last saw the deceased alive on 2-9, 1959, and that death occurred at 4.40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Luis M. Cuza M.D. ADDRESS (Street, city or town, state): Cecil Avenue, DATE SIGNED: Feb 10, 1959

PHYSICIAN'S NAME (Type): Luis M. Cuza — North East, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 12/59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d LOCATION (City, town, or county) (State): Elkton, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 '59

24b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1778 CERTIFICATE OF DEATH

Reg. Dist. No. 1773

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4yrs.4mo.17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: Adams
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle G. — Last HOLMES

4. DATE OF DEATH: Month February — Day 16 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-27-98

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: Not ascertainable

11. BIRTHPLACE (State or foreign country): Seattle, Washington

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Not ascertainable

14. MOTHER'S MAIDEN NAME: Margaret (?)Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): Peacetime

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
490X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, generalized, severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19 VA

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 30 19 54, to February 16 1959, and that death occurred at 7:50 p.m., from the causes and on the date stated above

ACTUAL SIGNATURE: S. P. LACERVA M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 2-18-59

PHYSICIAN'S NAME (Type): S. P. LACERVA — Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2/25/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1779

Reg. Dist. No. 01774

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, Rural

c. LENGTH OF STAY IN 1b: Life

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville, Rural

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Richmond Hill

d. STREET ADDRESS: Richmond Hill

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Arthur Last: Hornbarger

4. DATE OF DEATH: Month: 2 Day: 2 Year: 1959

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-7- 1912

9 AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land Lord

10b. KIND OF BUSINESS OR INDUSTRY: Appts.

11. BIRTHPLACE (State or foreign country): Md.

12 CITIZEN OF WHAT COUNTRY? U S A

13 FATHER'S NAME: Arthur W. Hornbarger

14. MOTHER'S MAIDEN NAME: Nellie Bines. ~~Bnes~~

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: 717-07-5572

INFORMANT: .Thelma Hornbarger, Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Carcinoma
163X
DUE TO (b): Upper Lobe Rt. Lung —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1958 to Feb 2, 1959 that I last saw the deceased alive on Feb-2, 1959, and that death occurred at 8.50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D.

ADDRESS (Street, city or town, state): Port Deposit

DATE SIGNED: 2-3-59

PHYSICIAN'S NAME (Type): Clarence I. Benson M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Buried

22b DATE THEREOF: 2-5-1959

22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23 FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Sons

ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 6 '59

24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

FOR STATE HEALTH DEPT.

Item 20 Film 239 1780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01775

Reg. Dist. No. 96

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4yrs.6mo.27days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2109 Lincoln Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle W. — Last JAMES JR

4. DATE OF DEATH: Month February — Day 19 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-29-31

9. AGE (In years last birthday): 27 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. James Sr.

14. MOTHER'S MAIDEN NAME: Mercedes Ferguson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exposure
932.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was found lying in the woods near the fence of VA Reservation

20c. TIME OF INJURY: Hour — o. m. / p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Woods

20f. (City or town) Cecil (County) Md. (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐
(Exposure)

ACTUAL SIGNATURE: R. C. DODSON, M.D.
EXAMINER'S NAME (Type): R. C. Dodson
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 2/21/59

22c. NAME OF CEMETERY OR CREMATORY: Oaklawn

22d. LOCATION (City, town, or county) Baltimore, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1781

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1125-5th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ISAAC — Middle: (NMI) — Last: JOHNSON
4. DATE OF DEATH: Month: Feb. — Day: 7 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 5, 1886
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): Custodian, Retired
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Fauquier Co., Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edmund Johnson
14. MOTHER'S MAIDEN NAME: Molly Minor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 5/7/17 3-8-19
16. SOCIAL SECURITY NO: 579-42-4561
17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Encephalomalacia of fronto-parietal area right due to arteriosclerosis, setere — INTERVAL BETWEEN ONSET AND DEATH: Unk.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral thrombosis due to arteriosclerosis of basilar artery — Unk.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from February 4, 1959 to Feb. 7, 1959 that I last saw the deceased alive on [illegible], and that death occurred at 1:25 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: E. S. Ells, M.D.
ADDRESS (Street, city or town, state): V. A. Hospital, Perry Point, Md.
DATE SIGNED: 2-7-59
PHYSICIAN'S NAME (Type): E. S. ELLS, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 2/9/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Ft. Myers, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PENNINGTON & SONS, Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: FEB 17 '59
24b. REGISTRAR'S SIGNATURE: C. Wm. L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01777
Reg. Dist. No

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 727 N. Dupont St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: L. — Last: Jones Jr.

4. DATE OF DEATH: Month: February — Day: 22 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11-21-25

9. AGE (In years last birthday): 33 yrs

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Not Ascertainable

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest L. Jones Sr.

14. MOTHER'S MAIDEN NAME: Eva M. Laurey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO: 221 14 5386

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema and congestion, bilateral, severe — INTERVAL BETWEEN ONSET AND DEATH: 4 to 5 hours

DUE TO
(b) Chronic Brain Syndrome associated with brain trauma left side — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Grand Mal (Clinical) — Unknown

PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. C. Dodson M D

EXAMINER'S NAME (Type): R. C. DODSON, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 2-22-59

22a. BURIAL CREMATION REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-22-59

22c. NAME OF CEMETERY OR CREMATORY: Beverly National Cemetery

22d LOCATION (City, town, or county) (State): Beverly, N.J.

23 FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Thos L Krauch

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1783

CERTIFICATE OF DEATH

Reg. Dist. No. 01778

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): X Rising Sun

d. NAME OF HOSPITAL (If not in haspitol, give street address) OR NSTITUTION: Graybeal Nursing Home

d. STREET ADDRESS: Mount Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Phillip Middle: Rowland Last: Kyle

4. DATE OF DEATH: Month: February Day: 18 Year: 19 59

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1885

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Creamery

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Kyle

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO.: 216-05-8928

INFORMANT: Mrs. Claude Yates Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the left side of face and

190.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): eye and skull

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER S GN FICANT CONDIT ONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN N PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home farm, factary, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19___, to 2-16-59, 19___, that I last saw the deceased alive on 2-16-59, 19___, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C.Dodson M.D. ADDRESS (Street, city or town, state): Rising Sun, Md. 2-20-59

PHYSICIAN'S NAME (Type): R.C.Dodson Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 21, '59

22c. NAME OF CEMETERY OR CREMATORY: Brookview

22d. LOCATION (City, town, or county) (State): Rising Sun, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. Earl Tyson Rising Sun Md

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shou[illegible] be fi ed with the registrar priar to burial, cremation, or removal, and in ony event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT. 1763 Item 9 Filed 3-12-59 et Reg. Dist. No. 01779

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 24 hurs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N.J. — b. COUNTY: Burlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burlington
d. STREET ADDRESS: 624 Washington Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Manzi
4. DATE OF DEATH: Month: 2 — Day: 26 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 9 6-11-1903
9. AGE (In years last birthday): 1911 47 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: Hair cutting
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Manzi
14. MOTHER'S MAIDEN NAME: Mary Napoli

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Manzi, 624 Washington Ave Burlington, N.J.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Torn Bowel with shock
816 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran his car under a truck
20c. TIME OF INJURY: Hour 8.15 a.m. p.m. — Month, Day, Year: 2 25 19 59 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☒ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 40 — 20f. (City or town): Elkton — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 2-27-59
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
22d. LOCATION (City, town, or county): Burlington (State): New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1784

CERTIFICATE OF DEATH

Reg. Dist. No. 01780

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Perryville, Rural
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Aikin

2. USUAL RESIDENCE (Where deceased lived If 'institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville, Rural
d. STREET ADDRESS: Aikin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Howard — Last McGuire

4. DATE OF DEATH: Month Feb. — Day 17, — Year 1959

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1883

9. AGE (In years last birthday): 7 5 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason

10b. KIND OF BUSINESS OR INDUSTRY: Penna. Railroad

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McGuire

14. MOTHER'S MAIDEN NAME: Emma Stewart

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 717-07-5276

INFORMANT: James H. McGuire — Address: Perryville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio. Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
DUE TO (b): Hypertensive Cardio Vascular disease — 5 yrs.
DUE TO (c): Mild Stroke — 3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year 19 — Hour a. m. p m

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1954, to Feb 17, 1959, that I last saw the deceased alive on Feb 17, 1959, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G.H. Richards Jr. M.D. — ADDRESS (Street, city or town, state): Perryville, Md — DATE SIGNED: 2-17-59

PHYSICIAN'S NAME (Type) G.H. Richards Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2/19/1959
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, R.F.D., Md.

23 FUNERAL DIRECTOR'S SIGNATURE: C.A. Patterson & Sons — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1764 **CERTIFICATE OF DEATH** Reg. Dist. No. 01781

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentmore Park, Rural Kennedyville
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First IVAR Middle Last MEURLING
4. DATE OF DEATH Month February Day 12, Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH January, 6, 1880
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer
10b. KIND OF BUSINESS OR INDUSTRY Machine
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edgar Meurling
14. MOTHER'S MAIDEN NAME Josephine Lindebled

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs. Mildred Meurling, Kennedyville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 446X
DUE TO (b) Nephrosclerosis — yrs
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) urinary retention due to prostatic hypertrophy
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 59 to Feb 12, 19 59, that I last saw the deceased alive on Feb 12, 19 59, and that death occurred at 3 00 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Wallace Obenshain M.D. ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 13 Feb 59
PHYSICIAN'S NAME (Type) WALLACE OBENSHAIN CECILTON MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 15, 1959
22c. NAME OF CEMETERY OR CREMATORY Crumpton Cem.
22d. LOCATION (City, town, or county) Crumpton, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Bloor ADDRESS Millington Md.
24a. REC'D BY REGISTRAR DATE FEB 19 '59
24b REGISTRAR'S SIGNATURE C. V. a P. Hearn

Ft. m 18 Film 282, 3/13/61 - AMS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1785

CERTIFICATE OF DEATH

01782

Reg. Dist. No. 96

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 mo. 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 211 Calvert
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: SAMUEL — Middle: (NMI) — Last: MILES

4. DATE OF DEATH: Month: February — Day: 16 — Year: 19 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-6-93
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Tabb Miles (Deceased)
14. MOTHER'S MAIDEN NAME: Lucy Brown (Deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 219 05 3335
17 INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic, anaplastic, Carcinoma of pancreas with wide spread — INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO: with metastasis to bone, lymph nodes stomach, liver, — unknown
162.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Portal veins thrombosis secondary to above
DUE TO: pancreas and left kidney
(c) Bronchopneumonia, bilateral, unresolved

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that VA I attended the deceased from November 10, 19 58, to February 16, 19 59, that I last saw the deceased alive on xxxxxxxxxxxxxxxxxx and that death occurred at 12:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard S Linn M.D. ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. DATE SIGNED: 2-17-59

PHYSICIAN'S NAME (Type): BERNARD S. LINN, M.D. Surgical Officer of the Day

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-19-59
22c. NAME OF CEMETERY OR CREMATORY: Crisfield
22d LOCATION (City, town or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wharton-Savage Fun. Home, New Church, Va.
24a. REC'D BY REGISTRAR DATE: FEB 20 '59
24b. REGISTRAR'S SIGNATURE: C. Irving L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1786

Reg. Dist. No. 01783

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Earleville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle R. — Last MOFFETT

4. DATE OF DEATH: Month February — Day 24, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May, 8,1875

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Moffett

14. MOTHER'S MAIDEN NAME: Elizabeth Grady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-36-8937A

17. INFORMANT: William Moffett, — Address: Massey, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cerebral thrombosis — 3 days

DUE TO

(c) Cerebral arteriosclerosis. — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): far advanced senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1958 to Feb 24, 1959, that I last saw the deceased alive on 24 Feb, 1959, and that death occurred at 3:30 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain, M.D. — M.D. ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 26 Feb 59

PHYSICIAN'S NAME (Type): Wallace G. Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 27, 1959

22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.

22d. LOCATION (City, town, or county) (State): Warwick, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward L. Moore — ADDRESS: Millington Md

24a. REC'D BY REGISTRAR — DATE MAR , '59

24b. REGISTRAR'S SIGNATURE: Clifford L. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: [illegible] may be retained by the hospital or attending physician.
TO FUNERAL DIRE[illegible] After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be [illegible]hed for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 sho[illegible] filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01784

1787

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 127 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Delaware — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 14 Holly Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle J. — Last MURPHY

4. DATE OF DEATH: Month 2 — Day 14 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-4-97

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: PETER MURPHY

14. MOTHER'S MAIDEN NAME: NORA DISKEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO: UNKNOWN

17. INFORMANT — Address: HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. CORONARY ARTERIOSCLEROSIS (MARKED) WITH CONGESTIVE — INTERVAL BETWEEN ONSET AND DEATH: Over 2 Yrs.

420.1

DUE TO (b) 2. HEART FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) CEREBRAL ARTERIOSCLEROSIS WITH CEREBRAL ATROPHY AND SECONDARY RIGHT HEMIPLEGIA — Over 2 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

VA

21. I certify that I attended the deceased from 10-9-58, 19____, to 2-14-59, 19XXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that death occurred at 7:50P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. C. Grasberger M.D.

ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md.

DATE SIGNED: 2-15-59

PHYSICIAN'S NAME (Type): J. C. GRASBERGER, M.D. Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 2-15-59

22c. NAME OF CEMETERY OR CREMATORY: Long Island National

22d. LOCATION (City, town, or county) (State): Farmingdale, L.I., N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Lee

ADDRESS: Havre De Grace, Md.

24a. REC'D BY REGISTRAR DATE: FEB 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1765

01785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 102 Mitchell ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: — Last: Ritter

4. DATE OF DEATH: Month: Feb — Day: 24 — Year: 1959

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/23/58

9. AGE (In years last birthday): ___ yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr Billie Ritter

14. MOTHER'S MAIDEN NAME: Friedhilde Kormelia Schuhmacher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute viral Gastro enteritis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): & Bronchitis

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mild Dehydration and Prematurity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): none

20c. TIME OF INJURY: Hour ___ a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 3, 1959 to Feb 23, 1959 that I last saw the deceased alive on Feb 23, 1959, and that death occurred at 2.55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest L. Tunnell M.D. — ADDRESS (Street, city or town, state): 245 E. High Street Elkton, Maryland — DATE SIGNED: 2-24-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 28/59

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town or county) (State): Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01786

1788

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: CECIL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN
c. LENGTH OF STAY IN 1b: 46 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN
d. STREET ADDRESS: E. MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AMY Middle VIRGINIA Last ROBINSON

4. DATE OF DEATH: Month FEB. Day 18 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 27, 1912

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOK KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: FEED WAREHOUSE

11. BIRTHPLACE (State or foreign country): RISING SUN, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEWIS A. CROTHERS

14. MOTHER'S MAIDEN NAME: VIOLA M. LYNCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 164-10-6364

17. INFORMANT: CLARA LOVE
Address: CONOWINGO, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Widespread adeno carcinoma
DUE TO
199.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ a. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/1 19 58, to 2/18 19 59, that I last saw the deceased alive on Feb 18 19 59, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D.
ADDRESS (Street, city or town, state): Rising Sun, Md.
DATE SIGNED: Feb 21 59

PHYSICIAN'S NAME (Type): N. J. Taylor

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/21/59

22c. NAME OF CEMETERY OR CREMATORY: FRIENDS

22d. LOCATION (City, town, or county): CALVERT (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph M Reed, Rising Sun, Md

24a. REC'D BY REGISTRAR
DATE: FEB 20 '59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1766 **CERTIFICATE OF DEATH** 01787

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b 4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Emma Middle T Last Rutter
4. DATE OF DEATH Month 2 Day 4 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 23, 1876
9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Ret. 15 yrs
10b. KIND OF BUSINESS OR INDUSTRY Atlas Powder Co
11. BIRTHPLACE (State or foreign country) North East, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME J. Alexander Rutter
14. MOTHER'S MAIDEN NAME Rebecca Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 221-03-0073
17. INFORMANT Robert C. Reeder Sr. Address 339 Tuttle Parkway Westfield N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage and Shock. — INTERVAL BETWEEN ONSET AND DEATH
4621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Hemorrhage from ruptured Esophageal Varices
DUE TO (c) Cardio Vascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1959 to Feb 4, 1959 that I last saw the deceased alive on Feb. 4, 1959, and that death occurred at 9:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE H. Arthur Cantwell M.D. ADDRESS (Street, city or town, state) North East Maryland DATE SIGNED

PHYSICIAN'S NAME (Type) H. Arthur Cantwell, M.D. North East, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/7/59
22c. NAME OF CEMETERY OR CREMATORY Methodist
22d. LOCATION (City, town, or county) (State) North East, Cecil, Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant ADDRESS North East Md
24a. REC'D BY REGISTRAR DATE FEB 9 '59
24b REGISTRAR'S SIGNATURE Ivan S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1767 — Reg. Dist. No. 01788

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle L. — Last SHELTON

4. DATE OF DEATH: Month February — Day 27, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 23, 1877

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Shelton

14. MOTHER'S MAIDEN NAME: Sarah L. Registar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-22-3583

17. INFORMANT — Address: Mrs. Elizabeth Shelton, Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion acute — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary artery disesae. — years.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bilateral inguinal herniae.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25, 19 59, to Feb 27, 19 59, that I last saw the deceased alive on Feb 27, 19 59, and that death occurred at 10:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Chesnain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 2 Mar 59

PHYSICIAN'S NAME (Type): Wallace Chesnain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington Md

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1789

01789

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Cecil — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural

LENGTH OF STAY (In this place): Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Cecil

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Md. Rural

STREET ADDRESS (If rural give location): Rout 276

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Simcoe

4. DATE OF DEATH: (Month) Feb. (Day) 1 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Single	March 30, 1883	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Laborer	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamen Simcoe	Mary Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	220-18-7236A	R.B. Marshall, Port Deposit, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE(S) DUE TO (B): Arteriosclerotic Heart disease — 5

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 19 59, to 2/1, 19 59, that I last saw the deceased alive on 2/1, 19 59, and that death occurred at 7:45 M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. — **ADDRESS** (Street, city, town, state) [illegible] Port Deposit Md — **DATE SIGNED** 2/3/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-4-1959	West Nottingham	Port Deposit, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 5 59	Carlton L. Kraus	[signature]	Perryville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1790 CERTIFICATE OF DEATH

Reg. Dist. No. 01790

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Ella Middle: McCall Last: Simers
4. DATE OF DEATH: Month: February Day: 26 Year: 1959
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Anderson McCall
14. MOTHER'S MAIDEN NAME: Hettie Lackland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Robert Simers Rising Sun, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cronic Myocardicis — INTERVAL BETWEEN ONSET AND DEATH:

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): General Artterio Sclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1958, 19____, to Feb 25, 19 59, that I last saw the deceased alive on Feb 25, 19 59, and that death occurred at 5.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. ADDRESS (Street, city or town, state): Rising Sun, Maryland DATE SIGNED:

PHYSICIAN'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 1-59
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer
22d. LOCATION (City, town, or county) (State): Rising Sun, cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph K Grant ADDRESS: North East Md
24a. REC'D BY REGISTRAR DATE: MAR 2 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1768 — Reg. Dist. No. 1791

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Univ. Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rd # 3 Elkton.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: Christine — Last: Smith
4. DATE OF DEATH: Month: 2 — Day: 25 — Year: 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-25-59
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months | Days | Hours: 6 | Min.: 00
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Elkton Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Lee Smith
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Wyant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Robert Lee Smith Rd#3 Elkton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Respiratory failure — 5 hrs
DUE TO (c): Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-25, 1959, to 2-25, 1959, that I last saw the deceased alive on 2-25, 1959, and that death occurred at 5:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M D
ADDRESS (Street, city or town, state): North East, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): LUIS M. CUZA

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 2-26-59
22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
22d LOCATION (City, town, or county): Elkton (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: N. Walter Du Boy Jr.
ADDRESS: Elkton
24a REC'D BY REGISTRAR DATE: MAR 2 '59
24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1769 — Reg. Dist. No. 01792

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 10 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City,
d. STREET ADDRESS: Lewis Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle ALBERT — Last STAPP

4. DATE OF DEATH: Month February — Day 20 — Year 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 30, 1893

9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maint. Supt.

10b. KIND OF BUSINESS OR INDUSTRY: C. and D. Canal

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Stapp

14. MOTHER'S MAIDEN NAME: Mary Krastel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 169-20-1586

17. INFORMANT — Address: Mrs. Mildred R. Stapp Ches. City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Oh Hour

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Chronic myocarditis — one Year

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 14, 19 58 to Feb 22, 19 59, that I last saw the deceased alive on Feb 22, 19 59, and that death occurred at 11:40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry V. Davis MD — ADDRESS (Street, city or town, state): Chesapeake City Md. — DATE SIGNED: 2/20/59

PHYSICIAN'S NAME (Type): HENRY V. DAVIS M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/24/1959

22c. NAME OF CEMETERY OR CREMATORY: St. Roses Cemetery

22d. LOCATION (City, town, or county) (State): Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pippin Funeral Home Donald M. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1791 CERTIFICATE OF DEATH

01793

Reg. Dist. No. 97

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bainbridge
c. LENGTH OF STAY IN 1b: 10 minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 17 Gallagher Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: Ellen; Last: Vasco

4. DATE OF DEATH: Month: February; Day: 14; Year: 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 February 1959

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joseph Anthony Vasco

14. MOTHER'S MAIDEN NAME: Barbara Jane Kahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Record — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PREMATURE SEPARATION OF PLACENTA — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

761.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 February, 1959, to 14 February 1959, that I last saw the deceased alive on 14 February, 1959, and that death occurred at 9:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard B. Speaker M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): RICHARD B. SPEAKER LCDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/19/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: PERRYVILLE, MD.

24a. REC'D BY REGISTRAR DATE: FEB 19 '59

24b. REGISTRAR'S SIGNATURE: Inez S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1792

CERTIFICATE OF DEATH

Reg. Dist. No. 01794 96

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 8 mo. 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY: CHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXFORD
d. STREET ADDRESS: 27 North 4th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle D. — Last WALKER

4. DATE OF DEATH: Month February — Day 23, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Army Officer

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FRANKLIN WALKER

14. MOTHER'S MAIDEN NAME: LOUISA FITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: Hospital Records, VA Hospital, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 month
491 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1. Generalized marked arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 6, 1958 to February 23 1959 X that I last saw the deceased alive on [illegible] and that death occurred at 2:10 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): VA Hospital, Perry Point, Md.
DATE SIGNED: 2-23-59

PHYSICIAN'S NAME (Type): R. BURKE SUTTT, M.D., Acting Director, Professional Services

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-24-59
22c. NAME OF CEMETERY OR CREMATORY: New London
22d. LOCATION (City, town, or county) (State): New London, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1770 — Reg. Dist. No. 01795

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elk Mills
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Essie — Middle: R. — Last: Watts
4. DATE OF DEATH: Month: February — Day: 13 — Year: 1959

5. SEX: F
6. COLOR OR RACE: Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 9, 1883
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: House Work
11. BIRTHPLACE (State or foreign country): Havre De Grace, Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: No Information
14. MOTHER'S MAIDEN NAME: Margaret No Information

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Helen G. Wiley — 219 W. Park Place, Newark, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypertensive arteriosclerotic	
DUE TO	cardiovascular disease	unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteoporosis of spine with collapse of lumbar vertebrae
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 8, 19 59 to Feb. 13, 19 59 that I last saw the deceased alive on Feb. 13, 19 59, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main Street — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-17-1959
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
22d. LOCATION (City, town, or county) (State): R. D. Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Donald M. Pippin — ADDRESS: Elkton, Md.
W. H. Pippin Funeral Home

24a. REC'D BY REGISTRAR DATE: FEB 19 '59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1771 — Reg. Dist. No. 01796

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: UNION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELKTON — RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: DIANE — Middle: E — Last: WHITE
4. DATE OF DEATH: Month: Feb — Day: 9 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-31-1955
9. AGE (In years last birthday): 3 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: RICHARD E. WHITE
14. MOTHER'S MAIDEN NAME: POLLY ANN SPENCE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT — Address: Richard E White Elkton RD Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bilateral Lobar Pneumonia	4 days
DUE TO	590X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Upper Resp. Infection	3wks
DUE TO (c)	Acute Nephritis	Unk?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac Failure
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Feb, 1959 to 9 Feb, 1959 that I last saw the deceased alive on 9 Feb, 1959, and that death occurred at 9:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George J Kreis M.D. — ADDRESS (Street, city or town, state): Elkton, Md — DATE SIGNED:
PHYSICIAN'S NAME (Type): George E. J. Kreis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-12-1959
22c. NAME OF CEMETERY OR CREMATORY: Methodist
22d. LOCATION (City, town, or county) (State): North East Cecil Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kreis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1793 CERTIFICATE OF DEATH

Reg. Dist. No. 01797

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 127 N. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Port Deposit
d. STREET ADDRESS: 127 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: Wesley — Last: Williams

4. DATE OF DEATH: Month: Feb. — Day: 13 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 17, 1876

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Fighter

10b. KIND OF BUSINESS OR INDUSTRY: U S V. Hospital.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W. Williams

14. MOTHER'S MAIDEN NAME: Amelia Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-6226

INFORMANT: Mrs. Minnie B. Williams, Address: Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b): Paralysis left side and Blind — 4 yrs

DUE TO (c): Arterio-Sclerosis — 7 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

Arterial Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb-8, 1959, to Feb 12, 1959, that I last saw the deceased alive on Feb-12-, 1959, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit — DATE SIGNED: 2/14/59

PHYSICIAN'S NAME (Type): Clarence I. Benson M.D. — Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-15-1959

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A Patterson & Sons — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kness

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VS A1S (4)
15M 9/58